

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41070

State File No.

5023

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (In this place) <u>20 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS <u>630 West 60th Terrace</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>				d. STREET ADDRESS <u>630 West 60th Terrace</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>GLADYS</u>		b. (Middle) <u>C.</u>		c. (Last) <u>WAGNER</u>	
4. DATE OF DEATH		(Month) <u>Nov.</u>		(Day) <u>26,</u>		(Year) <u>1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 27, 1900</u>	9. AGE (In years last birthday) <u>50</u>	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 1 YEAR Hours <u> </u> Min. <u> </u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>James E. Cance</u>		13b. MOTHER'S MAIDEN NAME <u>Verna C. Casey</u>		14. NAME OF HUSBAND OR WIFE <u>Clay S. Wagner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Clay C. Wagner, 630 W. 60th Terr. K.C. Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Ovary</u> ANTECEDENT CAUSES <u>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>With Carcinomatosis</u> DUE TO (c) <u> </u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>175h</u>	
19a. DATE OF OPERATION <u>Oct 14, 50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Generalized Carcinomatosis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u> </u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u> </u>		21f. HOW DID INJURY OCCUR? <u> </u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u> </u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u> </u>			
22. I hereby certify that I attended the deceased from <u>12-2</u> , 19 <u>49</u> , to <u>11-26</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>11-24</u> , 19 <u>50</u> , and that death occurred at <u> </u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>J. J. Cochrane</u>		23b. ADDRESS <u>315 Alameda Rd.</u>		23c. DATE SIGNED <u>11/27/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/28/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>		24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>11-28-50</u>		REGISTRAR'S SIGNATURE <u>Steraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>STINE & McCURE, Kansas City, Missouri</u>			

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. L. P. Engel L.O. 3150
Phys. Fred Bldg

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Max E. Meyer

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

*4555
R. E. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.